STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PUBLIC HEARING -- HOSPITAL BEDS

Wednesday, June 25, 2003
State of Michigan - Michigan Library and Historical Center
702 West Kalamazoo, 3rd Floor - Lake Ontario Room
Lansing, Michigan

ORAL TESTIMONY

Approximately 22 people were in attendance.

Wednesday, June 25, 2003 -- at 10:01 a.m.

MS. ROGERS: Good morning. My name is Brenda Rogers. I am Special Assistant to the Certificate of Need Commission from the Department of Community Health. Chairperson Renee Turner-Bailey has asked the Department to conduct today's hearing.

We are here today to take testimony concerning proposed revisions to the Review Standards for Hospital Beds. The proposed Certificate of Need Review Standards for Hospital Beds are being reviewed to allow for hospitals to relocate existing licensed hospital beds to a freestanding surgical outpatient facility (FSOF) or a different licensed hospital site, within the same health service area, if certain requirements are met.

Please be sure that you have signed the sign-in log. Packets can be found on the table. In the folder is a card to be completed if you wish to provide testimony. If you wish to speak, please hand your card to me. Additionally, if you have written testimony, please provide a copy of that as well. When you come up to speak, please state and print your name on the sign-in sheet at the podium. As indicated on the inside pocket of the packet, written testimony may be provided to the Department through July 2nd, 2003, at 5p.m.

We will begin the hearing by taking testimony from those of you who wish to speak. The hearing will continue until all testimony has been given, at which time we will adjourn. Today is Wednesday, June 25th, and we are now taking testimony.

First up, I have Ken Trester, representing Oakwood Healthcare.

MR. TRESTER: Good morning. My name is Ken Trester. I'm Senior Vice President in Planning for Oakwood Healthcare, Inc. I wish to comment on the proposed changes in the standards. The proposed language to change the CON standards to permit hospitals to relocate beds to freestanding surgical outpatient facilities is not consistent with the provisions enacted in PA 619. This inconsistency would, in our opinion, open the door to the proliferation of bed transfers far beyond those envisioned by the drafters of 619. The proposed standards omit the December 2nd, 2002 time threshold contained in 619 before which an FSOF must meet the criteria to be eligible as a receiving site for beds. Without this cutoff, an FSOF without four covered services today could add them over time to thus qualify as a receiving site for inpatient beds in the future. This open-ended invitation to add beds to any freestanding facility in Michigan was not at all the intent of the framers of 619.

We strongly urge the inclusion of the original language of PA 619 to this provision. Specifically, we refer to Section 22209, section (b), where it's, quote, "Subject to subsections 7 and 8, the physical relocation of licensed beds from a hospital licensed under part 215 to a freestanding surgical outpatient facility licensed under part 208 if that freestanding surgical outpatient satisfies each of the following criteria on December 2nd, 2002," which was the missing piece. For those of us who wish to limit the proliferation of beds, I would

anticipate general consensus that the limitations agreed upon in the original legislation should not be abandoned. Thank you.

MS. ROGERS: Thank you. Next, I have Barbara Jackson, Economic Alliance.

MS. JACKSON: Good morning. I'm Barbara Jackson, Regulatory Director for the Economic Alliance for Michigan. I'm providing brief testimony on behalf of Larry Horowitz, as at the last minute he wasn't able to attend. We feel the proposed action standards are not CON standards at all. Per statute, CON standards are to define need. There is nothing in these standards that describes a need that is attempting to be addressed. Yes, it's true in the past CON standards have focused on particular and specific situations, but these standards have been defined based on specific situations governed by need.

For example, in rural or U.P. geographic locales, there were more immediate standards that were put in effect or standards were exempted. No CON requirements for CT units for hospitals with ERs, if no other CT units are available within a certain radius. Metropolitan Hospital, the need for relocation was defined due to being landlocked. Beaumont Hospital, the need was defined as actual and existing high occupancy. However, there are no need criteria in these proposed standards. It's just an effort to preset those who are able or desiring to convert an FSOF to a hospital or to expand a hospital without any consideration of need at all.

EAM is certainly supportive of the CON Commission attempting to develop bed need standards that better define need. However, we feel that these draft standards do not begin to do so. We also believe it's a mistake to say that CON bed need standards have not been updated for many years. This methodology was just modified about two years ago, and also both the population and patient utilization data was also updated. In closing, we feel that these proposed standards is poorly drafted to accomplish what the Department stated it was attempting to do.

MS. ROGERS: Thank you, Barb. Cheryl Miller, with Trinity Health.

MS. MILLER: Good morning. My name is Cheryl Miller. I'm Senior Manager in Trinity Health's Corporate Strategic Planning Office. Thank you for the opportunity to provide input to the proposed revisions of the CON Review Standards for Hospital Beds.

Trinity Health is a Catholic health system that provides a range of healthcare services including inpatient acute care, nursing home care, home care, and hospice care in several locations throughout the state of Michigan; including the cities of Ann Arbor, Battle Creek, Cadillac, Grand Rapids, Grayling, Howell, Livonia, Clinton Township in Macomb County, Muskegon, Pontiac, Port Huron, and Saline. Additionally, Trinity Health owns a Michigan- licensed health maintenance organization.

Trinity Health has long supported the CON program in Michigan. While the CON process is not perfect, it has played an important role in balancing cost, quality, and access goals in our state. The proposed standards that are the subject of today's public hearing include the same poor public policy language as contained in Section 22209, sub 3, of Public Act 619 of 2002. The bed relocation provisions of PA 619 and now these proposed bed standards undermine the CON process. They allow for significant bed relocation and new construction throughout the state without the benefit of a legitimate, comparative CON review process.

Further, the statewide bed relocation provision does so without the benefit of a thoughtful bed need methodology. Trinity cannot support any CON review standards or state statute that provides special consideration and regulatory exemption for two health systems as these proposed standards do. It should be noted that, pending judicial decisions, or unless Section 22209, sub 3, of PA 619 is repealed, no action can be taken by the Commission to adopt these standards. Thank you again for the opportunity to express continued concern about the abandonment of a system that has worked and can continue to work for the state of Michigan. Thanks.

MS. ROGERS: Thanks, Cheryl. Patrick O'Donovan from Beaumont Hospital.

MR. O'DONOVAN: Good morning. My name is Patrick O'Donovan, Director of Planning for Beaumont Hospitals. Thank you for the opportunity to provide comment on the proposed CON Standards for Hospital Beds which were made available at the June 10th CON Commission meeting.

Decisions to allow building of new hospitals or expansion of existing hospitals ought to be made within, not outside of, the CON process that have served our state well for over 30 years. It appears as if it is the CON Commission's desire to keep the prospect of new hospitals under the umbrella of CON, and we applaud that. However, the proposed hospital bed standards, as written, do not relate to need for beds at all. They simply award new hospitals without any requirement to show need. The potential adverse consequences of allowing new hospitals to be built without any health planning are numerous and have been espoused by many over the last few weeks and months.

As identified in our issue paper sent to the Commission in late May, some of these adverse consequences include the following; first, reduced utilization at existing area hospitals, especially DMC's Huron Valley Hospital, that is within ten miles of both sites of the proposed new hospital. Note also that the state is considering financial assistance for the DMC. If that occurs, and DMC's Huron Valley Hospital is subsequently hurt by two new hospitals, will more financial assistance be needed? And what about the Pontiac Hospitals? If they're hurt by two new hospitals, will the state be asked to provide financial assistance to them as well?

Second, the DMC has announced plans to cut back services in Detroit, which will reduce access to care for Detroit residents. If, in addition, hospital beds are relocated from Detroit to the suburbs, this will further reduce healthcare access in Detroit. Who is planning for hospital beds in the city of Detroit?

And, third, increased competition for a limited number of health professionals will raise hospital costs and worsen professional staff shortages, thereby affecting quality of care. Under the new law, the CON Commission is already required to review the existing CON Review Standards pertaining to the increase or relocation of licensed beds. It would be logical to incorporate within this review a rational approach for determining the need for new hospitals. A rational, data-driven planning analysis may demonstrate the need for a new hospital in western Oakland County on the basis of access. However, such an analysis is unlikely to demonstrate the need for two new hospitals within eight miles of each other. There is an active hospital beds ad hoc committee that has been meeting to review and make recommendations to the Commission regarding the bed need methodology. This committee, or a different committee appointed by the Commission, could be directed to look specifically at the need for new hospitals.

In our issue paper, we made reference to a "drive time" approach that could be used to determine the need for new hospitals. This approach would allow new hospitals to be built if there's a critical mass of people without appropriate access to a hospital. Under this approach, access to hospitals could be measured by drive times, and appropriate access would likely be defined differently in urban versus rural locations. A brief description of how this methodology could be applied statewide has been sent to the Department, and a copy is attached to our written testimony. Beaumont understands this is a complex issue involving hospital access. Yet the CON Commission has faced such issues before and has responded in a thoughtful and responsible manner. The CON Commission has been open to and has supported modifications to CON Review Standards to increase access to health services for rural residents.

For example, the megavoltage radiation therapy or MRT standards were modified to allow a new MRT service if the proposed service is located in a rural county and 60 miles or more from the nearest existing MRT service.

Our second example, the surgical services standards were modified to allow rural hospitals with only one operating room to expand to two operating rooms in order to better accommodate emergency surgery. To conclude, Beaumont urges the CON Commission not to adopt the currently proposed hospital bed standards, but instead undertake a rational, thoughtful planning process to determine the need, if any, for new hospitals in western Oakland County or anywhere else in the state where such need may arise in the future. New hospitals should be built because people need them, not to make money for their sponsoring organizations. Allowing new hospitals to be built without planning criteria will destroy the integrity and credibility of the CON process in our state. Thank you.

MS. ROGERS: Thanks, Patrick. Robert Asmussen, St. John Health.

MR. ASMUSSEN: Good morning. I am Bob Asmussen, Vice President of Strategic Planning for St. John Health, and have provided suggestive alterations to the proposed standard. I would begin by saying that, obviously, from our perspective, Public Act 619 speaks for itself; but to the extent that the Commission and the Department would like to contemplate a standard that mirrors Public Act 619, what we have done is provide some suggested alterations to that standard draft that you presented to us on June 10. I neglected to indicate in the cover note that it is the black, bolded language that we would suggest in terms of additional language. Essentially, all we've done is compare Public Act 619 to the standard, and hopefully you'll find those recommended alterations to be -- bring the standard more in line with Public Act 619. Thank you.

MS. ROGERS: Thank you. Liz Palazzolo, Henry Ford Health System.

MS. PALAZZOLO: Good morning. My name is Liz Palazzolo, and I'm Director of Planning and Research at Henry Ford Health System. I'd like to speak this morning in support of the proposed changes to the Certificate of Need Standards for Hospital Beds.

In specific, we agree that the provision to allow hospitals to relocate existing licensed hospital beds to a freestanding surgical outpatient facility, if certain criteria are met, is a positive change that introduces flexibility to the rules for hospital beds. This flexibility is desperately needed by urban hospital systems, such as ours, that struggle to maintain access to economically disadvantaged populations. The ability to relocate a limited number of hospital beds to our West Bloomfield site will allow us to improve access for our suburban patients, while at the same time supporting our commitment to healthcare in the city of Detroit. Although we have a sizable investment in our West Bloomfield Medical Center, which is essentially a hospital without beds, we are unable to provide a full continuum of care when patients who use that site require hospitalization.

Consequently, transfers and hand-offs must be made. These transfers are costly in terms of transportation, duplication, and patient discomfort. Other providers have expressed concern that bed relocations, such as those permitted under PA 619, will have widespread application throughout the state and will cause great harm. We believe that the proposed bed need standards specifically limit bed relocations to a freestanding surgical outpatient facility or existing hospital that is under common ownership with a Detroit-based health system. Therefore, the proposed standards represent a narrowing of the bed relocation provisions that are described in PA 619. To further address provider concerns that large, new hospitals will be created, we are also proposing that hospitals created under these new provisions be limited to 300 beds in nonrural counties. And that would be in Section 6, sub 5a. To insure that access to care will be maintained in the city of Detroit, we support the notion that transfer of beds from facilities that are actually located in Detroit be limited to 35 percent of the total licensed beds at that facility, and that such relocation be permitted only once from any facility that is part of the Detroit-based health system.

Finally, we are proposing that the requirement to include a portion of operational beds and the relocated beds be eliminated since it does not serve any meaningful purpose. This requirement, as written, will be difficult to define and enforce and will not allow sufficient flexibility to adjust capacity to demand as necessary to maintain appropriate access. We believe that the revisions that I have outlined will serve three major purposes. The first is that new hospitals created under these standards will be limited in size to 300 beds. Secondly, it is clearly stated that no more than 300 beds can be transferred from facilities located in Detroit, and that transfers from Detroit-based systems can occur only one time.

Finally, eliminating the operational bed requirement will simplify and streamline the language in the standards and will also eliminate the need to define and monitor operational bed capacity, and will guarantee that access to operational inpatient beds in Detroit will not change. Adoption of these standards by the Certificate of Need Commission will strengthen and support the ability of the Detroit-based health systems to continue their urban mission. It will also enhance access for the thousands of patients that use our West Bloomfield facility.

The old notion that hospital construction can only lead to higher consumer and purchaser cost is not supported by more recent research studies. These studies show that purchasers of care are advantaged by the

presence of multiple providers, because their bargaining and negotiating power is enhanced. Furthermore, in a more competitive environment, providers are given incentive to improve efficiency, enhance quality, and elevate services as they seek to attract more customers. Permitting urban hospital systems to serve their suburban patients in a setting close to home will help to level the playing field between urban and suburban providers, especially in light of the recent changes allowing related or unrelated hospitals to relocate beds fairly freely within a hospital subarea. The standards currently proposed will provide relief for the Detroit-based health systems, and are consistent with the objectives of the Certificate of Need program; that is, to provide appropriate access to health care services with an approach that balances cost and quality.

MS. ROGERS: Thank you. Peg Reihmer, Botsford Hospital.

MS. REIHMER: Good morning. My name is Peg Reihmer, and I'm Vice President of Planning, Marketing, and Development for Botsford Hospital, in Farmington Hills.

I'm here this morning to urge the Commission not to adopt revisions to the Certificate of Need Review Standards for Hospital Beds, which would provide for the relocation of beds from hospital to hospital, or from a hospital to a qualified freestanding outpatient surgical facility without meeting a standard of bed need that would otherwise apply.

From its inception in 1972, the Certificate of Need law has held as a core principle that only those facilities and services which are needed should be developed. Though the Certificate of Need process is not by any means perfect, it has served the citizens of the state well by balancing cost, quality, and reasonable standards of access. These proposed standards by requiring no demonstration of need, either for the relocation by a system of hospital beds within a health service area or for the creation of new hospitals for a narrowly defined set of providers, would undermine the Certificate of Need Program. There is a provision within PA 619 for periodic review of the Standards for Hospital Beds. There is an active ad hoc on that issue. They should finish their work, and if it is determined that additional hospital beds are required, all qualified applicants should have an opportunity to make proposals within a comparative, competitive review. It should be noted as well that at present the Commission does not have the authority to adopt these standards. I thank you as always for the opportunity to participate in the planning process.

MS. ROGERS: Thank you. Michael McMillan, UFCW Local 951.

MR. MCMILLAN: My name is Michael McMillan from the United Food and Commercial Workers Local 951. Thank you for this opportunity to testify today.

The need that has been discussed here is the need of some hospitals, not the need of the community, in our opinion. We believe the hospitals could not make the case for community need. That's why they went before the legislature to cook up a deal. Frankly, they got a half- baked deal when they cooked that up, one that I think no one was completely satisfied with. Then we went through the process of hearings. I testified at the beginning part of that, the hearings at the end of May. We went through a process of fairly extensive hearings in front of the Certificate of Need Commission; then through what I believe was legal flimflammery. We were denied a vote even of the Commission. Now we find ourselves on the courtroom steps. A little bit hard-baked deal in the courtroom, and hard to deny a vote. A judge will make a decision on this. I don't know how the decision is going to come out. I think we're probably here because nobody knows how that decision is going to come out. But now we find the people that didn't have the confidence in their arguments about need to bring them before an ad hoc or to bring them before the Commission -- by the way, I did serve on the Bed Need Ad Hoc Committee -- and then didn't even feel confident enough to allow a vote to happen among the Commission. Now they come looking for a guarantee on the downside in case the Court doesn't do what they want them to do. If for no other reason than process, we oppose that.

I would like to make one other comment, because there was during the Certificate of Need testimony what I think is a fairly distressing idea in trend. There was an argument that only two members of the Economic Alliance could testify before the Commission, even though unlimited numbers had testified for certain hospital systems. So, I think maybe it's important that I put on the record what the Economic Alliance is and what it means to those of us that are members.

It's a coalition of organizations and companies. As a unionist, I'm an elected representative of the United Food and Commercial Workers, but we also are members of the AFL-CIO. We don't think that should limit our opportunity to express our opinion in a democratic forum. We are members of the Economic Alliance. We're members of a lot of things. I don't think Methodists should be -- there should only be two that speak, either, or any other group of people. That is an insult and an assault on the process, in my opinion. So, we are highly angered about that, frankly. The Economic Alliance represents a large and broad group of companies, and a large and broad group of unions, and come before you. Obviously, we've been fairly successful because we're not trying to be silent -- there's not an attempt to silence us.

This is a new Commission. It's been expanded. Part of the expansion -- it has also included a limitation on ad hoc committees. I've served on eight ad hoc committees myself, and I look around at the people in this room, and I've seen them for a heck of a long time; the same folks show up all the time. And some have testified on this particular item in the same manner as I have, and on other items in opposite manners. What is going on inside of our organization as a reaction to being unable to speak or being -- or an attempt to limit our speech, and the successful attempt to prevent a vote is that the people in our organization who are, frankly, more on the fringe and way less amenable to a compromise become in charge. And their attitude is, "No damn way." And that's where we are now, and that's part of the reason we're testifying now. The folks in this room I've functioned with in many, many times creating deals and solutions that weren't perfect but solved a lot of the problems and were compromises. We find ourselves beginning in a new Commission with an inability to compromise because of the way the process is being used. I think that's a significant loss.

The Economic Alliance of Michigan represents somewhere -- if you take all of the unions and all of the companies that are there -- and there are many nonunion companies, by the way, involved. This isn't a union deal. We're very much a minority, even on the Economic Alliance. But we represent about -- the Alliance and all of their members touch about 80 percent of the private payers in the state of Michigan. We already are paying the big bills. And yet there are groups of people within this process that now want to make us the enemy. I would say to you that we write the checks that make the whole world sing. And if what this is about is eliminating the customer from the process, and eliminating the voice of the customer, we will oppose that in the legislature. We will oppose that in the courts. We will oppose that on any porch front that will allow us to speak and oppose it. We are not your enemies. We are your customers. I understand that we're not the one that walks through the door and gets the service, but we do pay for the service in a significant portion, and we already are paying the top prices that you're -- that at least are being considered. We also recognize that the needs of the hospitals and the desperation of the hospitals that are putting forward this proposal are real. We have not said that this problem is not real. When the percentage of payers that are us reaches a certain level, hospitals can't function.

In other words, when the nonpayers and the Medicaid and those areas where you're not getting paid the right amount for your services reaches a certain percentage, you can't function. It doesn't matter if you're in Grand Rapids, if you're in Detroit, and if you're in Ionia. There's not a hospital administrator in the state of Michigan that's so gifted that they could figure out how to run a hospital when that percentage of nonprivate payers reaches a certain point, and we recognize that. So, we stand opposed to this, and I guess my comments are -- to the folks in the room are thank you for the -- thank you for the rational compromises that you participated in so far, and I hope that the process continues to work in a way so that we can continue to make those rational compromises, because we're certainly not particularly thrilled with letting the legislature do this. And, frankly, we're not thrilled with letting the courts do it. But we will not agree to taking care of the downside of the group of people that have essentially asked that we not even have a voice in the process anymore. But how about we -- you know, this reminds me of my kids sitting in the living room betting on a football game. You know, his idea of a bet is if his team wins, I pay him two dollars. If my team wins, I don't pay him anything. We're not going to take on your downside and take care of you, frankly, after the treatment that we've experienced; and I probably haven't expressed the anger of our members enough. You know, we're not just a group of people that never talk to one another. We've already met over this item, and it was heated about why we should even participate anymore.

So, hopefully, we'll get to a point again where the people that can make compromises and solutions can continue to work together and make this system -- this system and, frankly, the whole system of healthcare

work for all of us. We're still in a position, no matter what happens here, of going into bargaining and cutting benefits from people, and going into bargaining and not -- and cutting people out of benefits and reducing levels of benefits. And at some point, that changes the mix also.

So, we recognize the problem is huge and offer ourselves as hoping to continue to stay involved in solutions to that problem. Thank you very much for the opportunity to testify.

MS. ROGERS: Thanks, Mike. Do we have any further testimony? Okay. Hearing none, it is about 10:37a.m. and this hearing is adjourned. Thank you.

(At 10:37 a.m., proceedings concluded.)